Congress Review

Review of the European Association of Urology (EAU) Congress 2026

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THE VIBRANT city of London, UK, set the stage for Europe's leading urological gathering this year: the 41st Annual European Association of Urology (EAU) Congress. Held from 13th–16th March 2026 at the expansive ExCeL London centre, the Congress welcomed a record-breaking number of delegates from across the globe. Over four active days, attendees engaged with pioneering research, live surgical demonstrations, and forward-thinking discussions that highlighted the innovations continuing to redefine the field.

A THEATRICAL OPENING

The Opening Ceremony captured the soul of the host city, beginning with a memorable performance by West End singers featuring the iconic chorus from Mary Poppins. This theatrical introduction set an energetic tone for the Congress, celebrating London's rich culture while initiating a programme of scientific excellence. Following the performance, EAU Secretary General Arnulf Stenzl took to the stage to warmly welcome delegates. He reflected on the continued growth of the Congress, highlighting the remarkable number of submissions and the ever-expanding global reach of the EAU. Emphasising the importance of collaboration, Stenzl commended the collective efforts of the international urological community in advancing patient care and innovation.

RECOGNISING EXCELLENCE: EAU ANNUAL AWARDS

A key highlight of the ceremony was the presentation of the prestigious EAU Annual Awards, honouring individuals whose contributions have significantly shaped the field. The EAU Willy Gregoir Medal was awarded to Mark Emberton, University College London, UK; and University College London Hospitals NHS Foundation Trust, UK, in recognition of his outstanding contributions to the development of urology across Europe. The EAU Frans Debruyne Lifetime Achievement Award was presented to Jens Rassweiler, Department of Urology, SLK Kliniken Heilbronn, University of Heidelberg, Germany, celebrating a distinguished career spanning more than 4 decades, marked by leadership and enduring impact on the EAU's growth and activities.

Emerging talent was also recognised, with Laura Mertens, Department of Urology, the Netherlands Cancer Institute (Antoni van Leeuwenhoek Hospital), Amsterdam, the Netherlands, receiving the EAU Crystal Matula Award, highlighting her exceptional promise as a young academic urologist set to shape the future of the specialty. Innovation in the field was honoured through the EAU Innovators in Urology Award, presented to Lars Dyrskjøt, Department of Molecular Medicine, Aarhus

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University Hospital; and Department of Clinical Medicine, Aarhus University, Denmark, for his groundbreaking work in liquid biopsies and their transformative applications in the diagnosis and management of urological diseases. Meanwhile, Rosalind Eeles, The Institute of Cancer Research and The Royal Marsden NHS Foundation Trust, London, UK, was recognised with the EAU Prostate Cancer Research Award for her outstanding contribution to clinical and experimental prostate cancer research.

The ceremony concluded on a celebratory note, reflecting its theatrical opening and setting the scene for a congress defined by innovation and collaboration. Across the comprehensive and diverse scientific programme, delegates explored a wide array of cutting-edge topics in the field, from advances in diagnostic pathways to novel therapeutic strategies that are shaping the future of clinical practice. Hands-on training sessions and educational initiatives once again played a central role, equipping the next generation of urologists with essential skills and knowledge and allowing them to carry forward the momentum of the present.

A HUB FOR INNOVATION AND COLLABORATION

Beyond the lecture halls, the vast exhibition space at ExCeL London was a hive of activity, as industry leaders showcased the latest technologies set to transform urological clinical practice. EAU 2026 reaffirmed its position as a global hub for scientific exchange, professional development, and innovation.

As the Congress drew to a close, EAU 2026 stood as an outstanding success, reinforcing the organisation's commitment to advancing urological care worldwide, beyond the walls of the ExCeL centre. With momentum continuing to build, the global urological community now looks ahead with anticipation to future congresses.

Could Reusable Catheters Cut Costs and Infections?

A UK-BASED randomised trial presented at the EAU Congress 2026 has found that reusing intermittent catheters, alongside single-use devices, is as safe as exclusive single-use catheterisation for urinary tract infection (UTI) risk, while significantly reducing antibiotic use.[1]

Intermittent catheters are widely used for long-term bladder management, but current practice in many countries, including the UK, relies on single-use devices due to concerns that reuse may increase infection risk. This has substantial financial and environmental implications, with the NHS spending approximately 200 million GBP annually on more than 100 million disposable catheters. Despite these concerns, evidence comparing infection risk between reusable and single-use catheters has remained inconclusive.

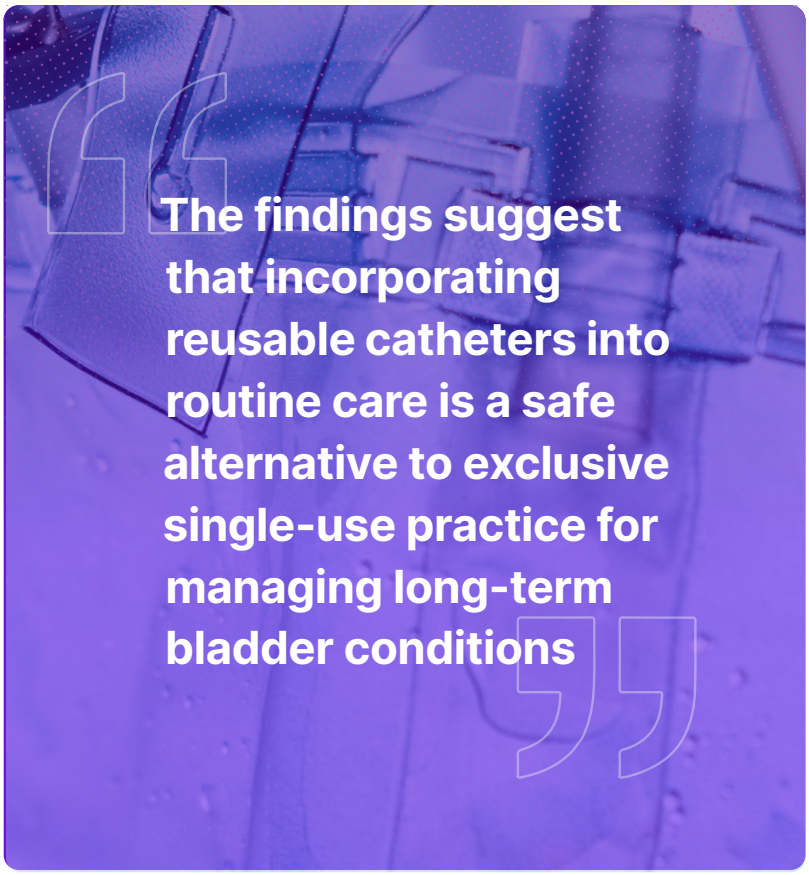
To address this, researchers conducted an open-label, randomised, non-inferiority trial involving 578 adult community-based catheter users across two UK centres, in Southampton and Glasgow. Participants were assigned to either a mixed-use approach, combining reusable and single-use catheters, or standard single-use practice over a 12-month period. The primary outcome was the occurrence of at least one microbiologically confirmed symptomatic UTI requiring self-care or medical attention.

Results from the per-protocol analysis showed that 28.7% of participants in the mixed-use group experienced at least one UTI episode, compared with 34.4% in the single-use group. Statistical analysis confirmed that the mixed-use approach was non-inferior to single-use catheterisation in terms of infection risk.

Notably, antibiotic use was 35% lower in the mixed-use group, suggesting a potential benefit in reducing antimicrobial exposure. Other outcomes, including quality of life, catheter-related complications, and overall adverse events, were broadly similar between the two groups. However, participants using reusable catheters reported more issues with catheter 'sticking', indicating a potential area for product improvement.

Participants in the mixed-use group reused catheters a median of nearly three times per day, demonstrating the practicality of this approach in real-world settings.

Overall, the findings suggest that incorporating reusable catheters into routine care is a safe alternative to exclusive single-use practice for managing long-term bladder conditions. The authors highlight that offering reusable options could reduce both healthcare costs and environmental impact while maintaining clinical safety. They also call for the development of improved reusable catheter designs to better meet patient needs.



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Repeated Intracavitary Therapy Improves UTUC Outcomes

A LARGE multi-institutional study presented at the EAU Congress 2026 has found that repeated intracavitary instillations of Bacillus Calmette–Guérin (BCG) or chemotherapy following endoscopic management of upper tract urothelial carcinoma (UTUC) are associated with improved recurrence-free survival (RFS), supporting their use in clinical practice.[2]

Endoscopic treatment is increasingly used in selected patients with UTUC to preserve renal function while maintaining acceptable oncological outcomes. However, local recurrence remains a significant concern. Adjuvant intracavitary therapies, including BCG and chemotherapeutic agents such as mitomycin and gemcitabine, have been proposed to reduce recurrence risk, though existing evidence has been limited and inconsistent.

To address this, researchers analysed data from a multi-institutional cohort comprising 334 patients who underwent 554 endoscopic interventions for UTUC. Patients were grouped based on adjuvant treatment strategy: no instillation, a single postoperative instillation, or multiple instillations. Outcomes were assessed using Kaplan–Meier survival analysis and Cox regression models, adjusting for key clinical factors, including tumour grade, size, smoking status, and the presence of carcinoma *in situ*.

The findings demonstrated a clear benefit for repeated treatment. Patients receiving multiple intracavitary instillations had significantly improved ipsilateral RFS compared with those receiving no treatment, with a 47% reduction in recurrence risk. In contrast, a single postoperative instillation did not significantly reduce recurrence.

Agent-specific analyses further reinforced these results. Multiple instillations of BCG were associated with a particularly strong reduction in recurrence risk, while repeated chemotherapy instillations also provided a significant benefit. Single-dose chemotherapy, however, showed no measurable impact on outcomes.

Importantly, the route of drug delivery, whether antegrade or retrograde, did not influence RFS, suggesting flexibility in clinical practice.

Overall, the study supports the use of repeated intracavitary therapy following endoscopic UTUC management to reduce recurrence risk. The authors highlight that these findings may help inform treatment protocols, although prospective studies are needed to confirm the benefits and optimise treatment strategies.

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MRI Biomarkers Could Predict Sperm Retrieval Success in Male Infertility

A NEW study presented at the EAU Congress 2026 provides evidence that MRI-derived biomarkers may predict sperm retrieval (SR) success in men with non-obstructive azoospermia, offering a potential non-invasive approach to guide clinical decision-making. These findings may help optimise patient selection for microsurgical testicular sperm extraction (microTESE), a procedure with variable outcomes.[3]

Among the 36 patients included, SR was successful in 38.9% and unsuccessful in 61.1%

Researchers analysed patients with non-obstructive azoospermia who underwent both testicular MRI and microTESE between 2022–2024, aiming to identify imaging parameters associated with successful SR. Quantitative MRI metrics reflecting testicular microstructure were assessed, including magnetisation transfer ratio, fat fraction, and multiple diffusion- and perfusion-related parameters. Partial Least Squares-Discriminant Analysis (PLS-DA) was used to identify variables linked to SR, with diagnostic performance evaluated using receiver operating characteristic analysis.

Among the 36 patients included, SR was successful in 38.9% and unsuccessful in 61.1%. The analysis demonstrated partial separation between groups, with higher fat fraction values associated with failed sperm retrieval. A predictive model based on the first PLS-DA component achieved an area under the curve of 0.831 ($p<0.001$), with 85.7% sensitivity and 77.3% specificity. The model showed a high negative predictive value of 89.5% and an overall accuracy of 80.6%.

A threshold value below −0.56759 strongly predicted successful SR, with an odds ratio of 20.4 (95% CI: 3.98–164.39; $p<0.001$).

These findings indicate that MRI-derived biomarkers can effectively distinguish between patients who are likely and unlikely to benefit from microTESE. Notably, the strong negative predictive value suggests a role for MRI in identifying individuals who may avoid unnecessary invasive procedures.

The study is limited by its small sample size and single-cohort design, which may restrict generalisability. Further validation in larger, multicentre studies is needed to confirm these findings and support integration into clinical practice.

This research highlights the potential of advanced imaging to transform patient selection in male infertility, supporting more personalised and less invasive treatment pathways.

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SABR Shows Durable Control in Inoperable Renal Cell Carcinoma

RESEARCH presented at the EAU Congress 2026 suggests that stereotactic ablative body radiotherapy (SABR) provides durable tumour control and favourable safety outcomes in patients with inoperable primary renal cell carcinoma (RCC), based on long-term pooled data from the FASTRACK trials.[4]

In this combined analysis of FASTRACK and FASTRACK II, 107 patients with biopsy-confirmed RCC deemed medically inoperable or at high risk for surgery were included, with a median follow-up of 5 years. Treatment protocols were consistent across both trials: tumours ≤4 cm received a single 26 Gy fraction, while larger tumours were treated with 42 Gy in three fractions. The primary endpoint was local control, assessed using Response Evaluation Criteria in Solid Tumors (RECIST) 1.1 criteria, with secondary endpoints including cancer-specific survival, freedom from distant progression, renal function, and toxicity.

The findings demonstrate sustained efficacy over time. Local control was 100% at 1 year and remained high at 98% at both 3 and 5 years, with only one reported local failure. Cancer-specific survival followed a similar trend, reaching 100% at 1 year and 98% at both 3 and 5 years. Freedom from distant progression declined modestly over time, from 97% at 1 year to 85% at 5 years.

Renal function declined gradually, with the estimated glomerular filtration rate decreasing by approximately 9.4 mL/min at 1 year and 15.8 mL/min at 5 years. Only one patient required dialysis, indicating a low incidence of severe renal impairment.

Safety outcomes were favourable. Grade 3 adverse events occurred in 7.8% of patients, including fatigue, vomiting, pain, and colonic obstruction, with all events reported within 2 years of treatment. No Grade 4 or 5 toxicities or late safety signals were observed.

As one of the largest prospective datasets evaluating SABR as a curative, non-invasive approach for RCC, these findings support its use in patients unsuitable for surgery. However, the absence of a comparator arm limits definitive conclusions, and randomised trials comparing SABR with surgical intervention are needed to establish its role in operable populations.

Penile Prosthesis Implantation: Outcomes and Patient Decision Regret

PENILE prosthesis implantation represents a treatment option for erectile dysfunction refractory to medications or less invasive therapies. This abstract, presented at the EAU Congress 2026, examined quality of life and decision regret after implantation while identifying factors associated with significant regret.[5]

The prospective study enrolled 86 patients (median age: 62 years; median BMI: 25.5 kg/m^2) undergoing penile prosthesis placement at a single tertiary referral centre. Participants received a comprehensive preoperative assessment, and perioperative and postoperative variables were recorded. The study employed the Quality of Life and Sexuality with Penile Prosthesis Questionnaire (QoLSPPQ), which assesses four subdomains: functional, personal, relational, and social. Decision regret was assessed using the Decision Regret Scale (DRS), with significant regret defined as >25%. Logistic regression was employed to identify predictors of significant regret.

A total of 90% of patients received a tricomponent prosthesis (77/86), with the remainder receiving a malleable prosthesis (9/86; 10%). Complications occurred in 13 patients (15%), whilst overall median decision regret was 24%, and 33% of patients experienced significant regret. Median QoLSPPQ scores were 22 for functional, 17 for personal, 17 for relational, and 12 for social domains.

Analysis revealed that postoperative complications increased the risk of significant regret 18-fold, and lower functional and relational satisfaction were also key predictors. Personal and social subdomains did not significantly influence regret.

These findings indicate that penile prosthesis implantation achieves generally favourable outcomes with a low complication rate. However, patient counselling should emphasise the possibility of decision regret, particularly when postoperative complications occur or functional and relational expectations are unmet.

> **“Analysis revealed that postoperative complications increased the risk of significant regret 18-fold”**

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Robotic versus Conventional Sacrocolpopexy for Pelvic Organ Prolapse

A MAJOR RCT, presented at the EAU Congress 2026, has found that robot-assisted laparoscopic (RAL) sacrocolpopexy offers comparable safety, effectiveness, and long-term costs to conventional laparoscopic (CL) sacrocolpopexy for pelvic organ prolapse.[6]

In this multicentre trial conducted across 15 centres, 366 females undergoing surgery for symptomatic pelvic organ prolapse were randomly assigned to CL or RAL sacrocolpopexy. Of these, 345 completed follow-up over 5 years. Baseline characteristics, including age, BMI, and prolapse severity, were comparable between groups.

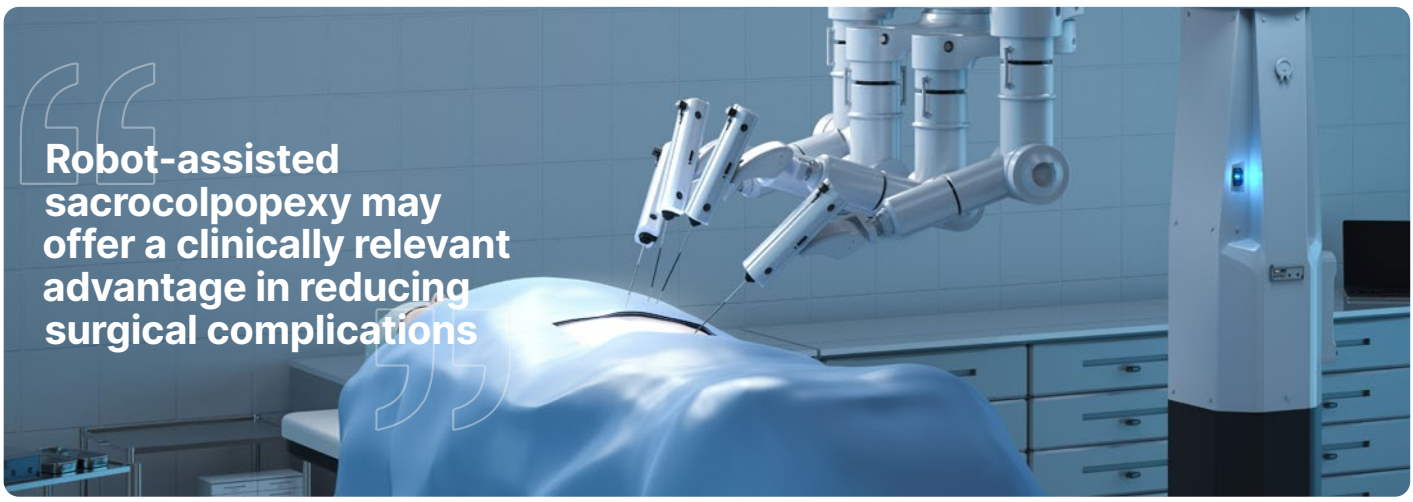
The primary endpoint, 30-day postoperative complications, showed no significant difference between approaches, occurring in 15.3% of the CL group and 11.7% of the RAL group (p=0.3213). However, when complications were analysed by type, surgical complications were notably lower in the RAL group than the CL group (2.9% versus 7.4%). Operative times were similar overall, although robotic procedures required longer set-up times (40 minutes versus 20 minutes; p<0.0001).

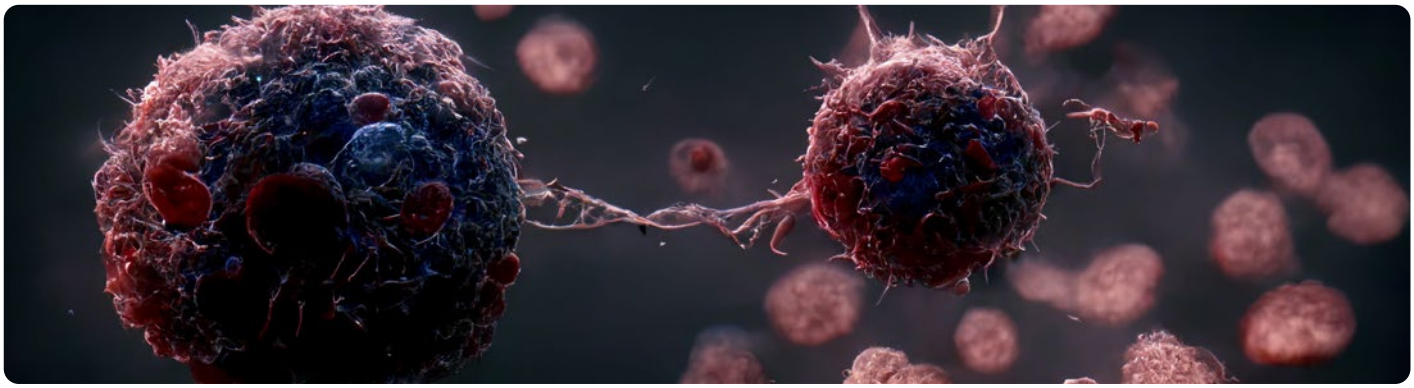
Long-term outcomes further reinforced the equivalence of the two techniques. There were no significant differences in anatomical or functional results, symptom burden, or quality of life measures between groups at 5 years. Importantly, healthcare costs, assessed using national data, were also comparable over 1-, 2-, and 5-year periods.

The findings suggest that both surgical approaches are safe and effective for the treatment of pelvic organ prolapse. However, robot-assisted sacrocolpopexy may offer a clinically relevant advantage in reducing surgical complications. This could be particularly meaningful for more complex cases, such as females with obesity or those undergoing repeat pelvic surgery.

Limitations include the potential variability in surgical expertise across centres and the extended recruitment period, which may influence outcomes. Nonetheless, the inclusion of 5-year follow-up offers valuable long-term data on the durability of both surgical approaches.

Overall, these results support the growing role of robotic assistance in pelvic reconstructive surgery, offering clinicians evidence to guide surgical decision-making in pelvic organ prolapse management.





Cancer-Associated Fibroblasts Drive Tumour Growth in High-Risk Bladder Cancer

A NEW study presented at the EAU Congress 2026 reveals that cancer-associated fibroblasts (CAF) play a central role in driving tumour growth in high-risk non-muscle-invasive bladder cancer (HR-NMIBC), offering new insights into disease biology and potential therapeutic targets.[7]

HR-NMIBC is typically treated with transurethral resection followed by Bacillus Calmette–Guérin (BCG) immunotherapy; however, outcomes vary significantly between molecular subtypes. In particular, the bombesin receptor subtype-3 (BRS3) subtype is associated with poor prognosis, epithelial-to-mesenchymal transition (EMT) features, and an immunosuppressive tumour microenvironment. This study aimed to determine whether these characteristics are driven by tumour-intrinsic processes or by the surrounding stromal environment.

Researchers performed an integrative analysis using transcriptomic data from 891 patients across multiple cohorts, alongside spatial and single-cell transcriptomics, to map tumour heterogeneity. *Ex vivo* experiments using patient-derived tumoroids were conducted to assess the functional impact of CAF signalling on tumour growth.

Results showed that *BRS3* tumours were significantly enriched for EMT, stromal, and immune-related signatures compared with other subtypes ($p<0.001$). However, EMT scores correlated more strongly with stromal signals ($R=0.82$; $p<0.001$) than with immune signatures ($R=0.57$; $p<0.001$), suggesting that the aggressive phenotype attributed to EMT may instead reflect stromal enrichment. Spatial transcriptomics further demonstrated that BRS3 signals were predominantly localised within stromal regions, while other subtypes were found in urothelial tumour areas. Even after excluding stromal regions, *BRS3* tumour cells were observed in close proximity to fibroblast-rich areas.

Functional validation supported these findings. Exposure of patient-derived tumoroids to CAF-conditioned medium resulted in a 21% increase in tumour cell viability compared with untreated controls ($p=0.017$), indicating that CAF-derived factors actively promote tumour growth.

These findings suggest that the poor prognosis associated with *BRS3* is driven not by tumour-intrinsic EMT programmes, but by interactions with a CAF-rich stromal niche. This highlights the tumour microenvironment, and specifically CAFs, as a key contributor to disease progression in HR-NMIBC.

The study is limited by its reliance on retrospective datasets and a relatively small number of samples for spatial and *ex vivo* analyses. Further research is needed to validate these findings and explore how targeting CAF-driven pathways could improve treatment outcomes.

Overall, this study provides important evidence that stromal interactions, rather than intrinsic tumour biology alone, underpin aggressive disease in HR-NMIBC, opening new avenues for therapeutic intervention.

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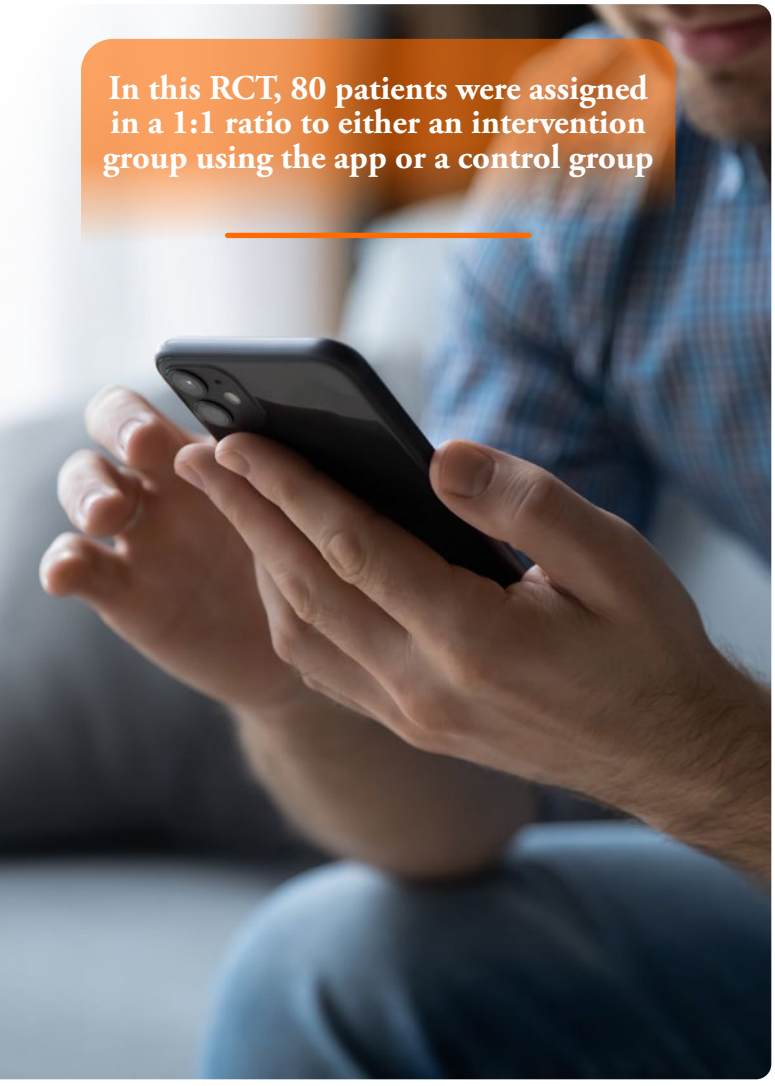
Mobile App Shows Significant Benefit in Premature Ejaculation Management

NEW DATA presented at the EAU Congress 2026 highlight the potential of digital therapeutics in the management of premature ejaculation, a common and often stigmatising sexual dysfunction associated with significant psychological distress and reduced quality of life.[8]

The CLIMACS study evaluated the effectiveness of a mobile health intervention, the Melonga App® (Prognoix Health B.V., Maastricht, the Netherlands) as an alternative or adjunct to conventional treatments such as pharmacotherapy and behavioural therapy. In this RCT, 80 patients were assigned in a 1:1 ratio to either an intervention group using the app or a control group, with a partial crossover after 12 weeks.



The primary endpoint was the change in the Premature Ejaculation Profile (PEP) score at 12 weeks. Among 66 patients with complete datasets, the intervention group demonstrated a marked improvement, with a mean PEP score increase of 4.4 points compared with 0.03 in the control group ($p<0.001$). Overall, PEP scores improved from 5.5 to 9.4 points in the intervention arm.

Secondary outcomes also showed significant benefits. Intravaginal Ejaculation Latency Time (IELT) increased by an average of 64 seconds, from 61 to 125 seconds ($p<0.001$), with a substantially greater improvement in the intervention group compared with controls (75.7 seconds versus 0.5 seconds; $p=0.001$). Sexuality-related quality of life (SQoL-M) improved from 32.8 to 43.1 points ($p<0.001$), while the Premature Ejaculation Diagnostic Tool (PEDT) score decreased from 16.4 to 11.9 points ($p<0.001$), indicating reduced symptom severity. Notably, 22% of patients met criteria for resolution of premature ejaculation following the mobile health intervention.

These findings suggest that app-based interventions can significantly improve both clinical outcomes and patient-reported measures in premature ejaculation. As digital health solutions continue to evolve, such tools may expand the therapeutic options available in urological practice, offering accessible and non-invasive support for patients who may be reluctant to seek traditional care.

PSMA PET/CT Reduces Unnecessary Prostate Biopsies

A MAJOR Phase III RCT, presented at the EAU Congress 2026, has shown that [^{68}Ga]Ga-prostate-specific membrane antigen (PSMA)-11 PET/CT can substantially reduce unnecessary prostate biopsies while maintaining detection of clinically significant prostate cancer in men with inconclusive MRI findings.[9]

Multi-parametric MRI is widely used to assess males with suspected prostate cancer, yet those with Prostate Imaging Reporting and Data System (PI-RADS) 2 or 3 lesions often present a diagnostic challenge. Despite a relatively low likelihood of clinically significant prostate cancer, many still undergo biopsy due to high clinical suspicion, resulting in avoidable invasive procedures being carried out in patients with insignificant disease. Building on earlier evidence, the PRIMARY2 trial investigated whether incorporating PSMA PET/CT into the diagnostic pathway could improve patient selection for biopsy without compromising cancer detection.

This investigator-initiated, multicentre, Phase III trial enrolled 660 biopsy-naive males with suspected clinically significant prostate cancer, PI-RADS 3 or PI-RADS 2 MRI with risk factors (e.g., prostate-specific antigen [PSA] density >0.1, strong family history), PSA ≤20 ng/mL, and ≤cT2. Participants were randomised to standard systematic transperineal biopsy or a PSMA PET/CT-guided pathway. In the experimental arm, only those with positive PET findings underwent targeted biopsy, while those with negative scans were monitored using PSA testing.

The results demonstrated a marked reduction in biopsy use. Nearly half of participants in the PSMA PET/CT arm avoided biopsy altogether (49%; p<0.001). Importantly, detection of clinically significant prostate cancer remained non-inferior compared with standard care (12% versus 16%; difference: –3.7%; p=0.009), meeting the trial's predefined criteria. At the same time, the PSMA-guided approach significantly reduced the diagnosis of insignificant prostate cancer (14% versus 32%; p<0.001), indicating a meaningful decrease in overdiagnosis.

These findings suggest that PSMA PET/CT can refine diagnostic decision-making by identifying patients who are unlikely to benefit from biopsy, while still capturing those with clinically important disease. By enabling more selective, targeted biopsies and reducing unnecessary procedures, this approach may help minimise patient burden and potential complications associated with overdiagnosis.

Although longer-term outcomes and broader implementation considerations will require further evaluation, the trial provides strong evidence supporting the integration of PSMA PET/CT into diagnostic pathways for males with equivocal MRI findings.

Nearly half of participants in the PSMA PET/CT arm avoided biopsy altogether (49%; p<0.001)

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Emergency Haematuria Linked to High Morbidity Rates

EMERGENCY haematuria is associated with high morbidity, significant readmission rates, and delayed diagnosis according to findings presented at the EAU Congress 2026.[10]

Emergency haematuria accounts for a notable proportion of urological admissions, representing approximately 15% of cases and around four per 1,000 emergency hospital presentations. In this large, international, prospective, observational study, data were collected from 8,500 patients across 382 centres over 1 year using a collaborative research model.

The median length of stay was 4 days (interquartile range: 2–8), while 90-day mortality reached 9.2% and 90-day readmission rates were 31%. At presentation, 5% of patients were haemodynamically unstable, 5% were septic, 11% required high-dependency care, and 21% required blood transfusion. Despite this clinical burden, ward-based management was successful in only 35% of cases.

The study identified considerable variation in inpatient management. Nearly half (47%) of patients did not undergo imaging during admission, and only 35% received any form of intervention. These findings suggest inconsistency in clinical pathways and potential missed opportunities for early diagnosis. Malignancy was identified as the underlying cause in 25% of cases during admission, evenly split between pre-existing and newly diagnosed disease, with an additional 5% diagnosed during follow-up. Urothelial carcinoma accounted for 20% of malignancies detected during admission, including 18% bladder and 2% upper tract, with a further 4% identified after discharge.

Time to diagnosis differed markedly depending on when investigations occurred. During admission, the median time to diagnosis was 1 day (0–2), compared with 21 days (10–41) following discharge. This delay highlights a critical gap in post discharge pathways and raises concerns regarding deferred investigation in patients with significant underlying pathology.

These findings demonstrate that emergency haematuria carries substantial clinical risk, with outcomes comparable to outpatient haematuria cohorts in terms of malignancy prevalence. However, low intervention rates and frequent discharge without definitive diagnosis remain key challenges.
The data support the need for structured early diagnostic pathways and prompt inpatient investigation. Avoiding discharge without a confirmed diagnosis, where feasible, may reduce delays and improve outcomes for patients presenting with emergency haematuria.

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